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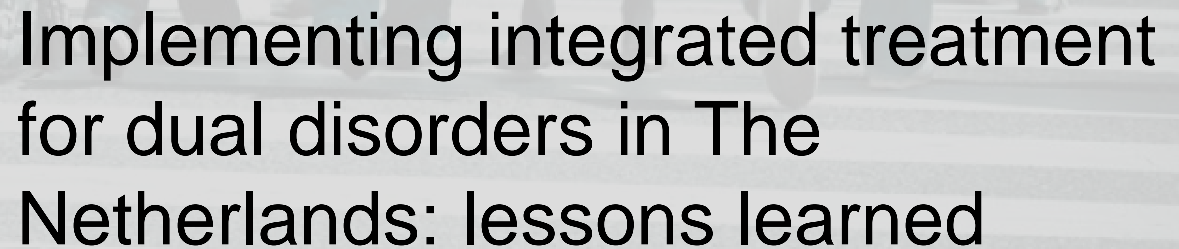


Implementing integrated treatment for dual disorders in The Netherlands: lessons learned

Anneke van Wamel

Who are we? LEDD

- 4 Mental health care institutions and Trimbos Institute
- Goal: central base of knowledge and experience
- Activities
  - Website: www.ledd.nl, downloads, information, literature
  - Bi-annual conferences
  - Platform meetings
  - Advice and training
  - Implementation projects
  - Products: books, implemantation guides, psycho-educational booklets etc.
  - Field standard integrated treatment

Programme

- Organization of Dutch care system
- Drug policy
- Integrated treatment model
- Implementation in The Netherlands
- Results
- What works?
- Discussion

Dutch care system

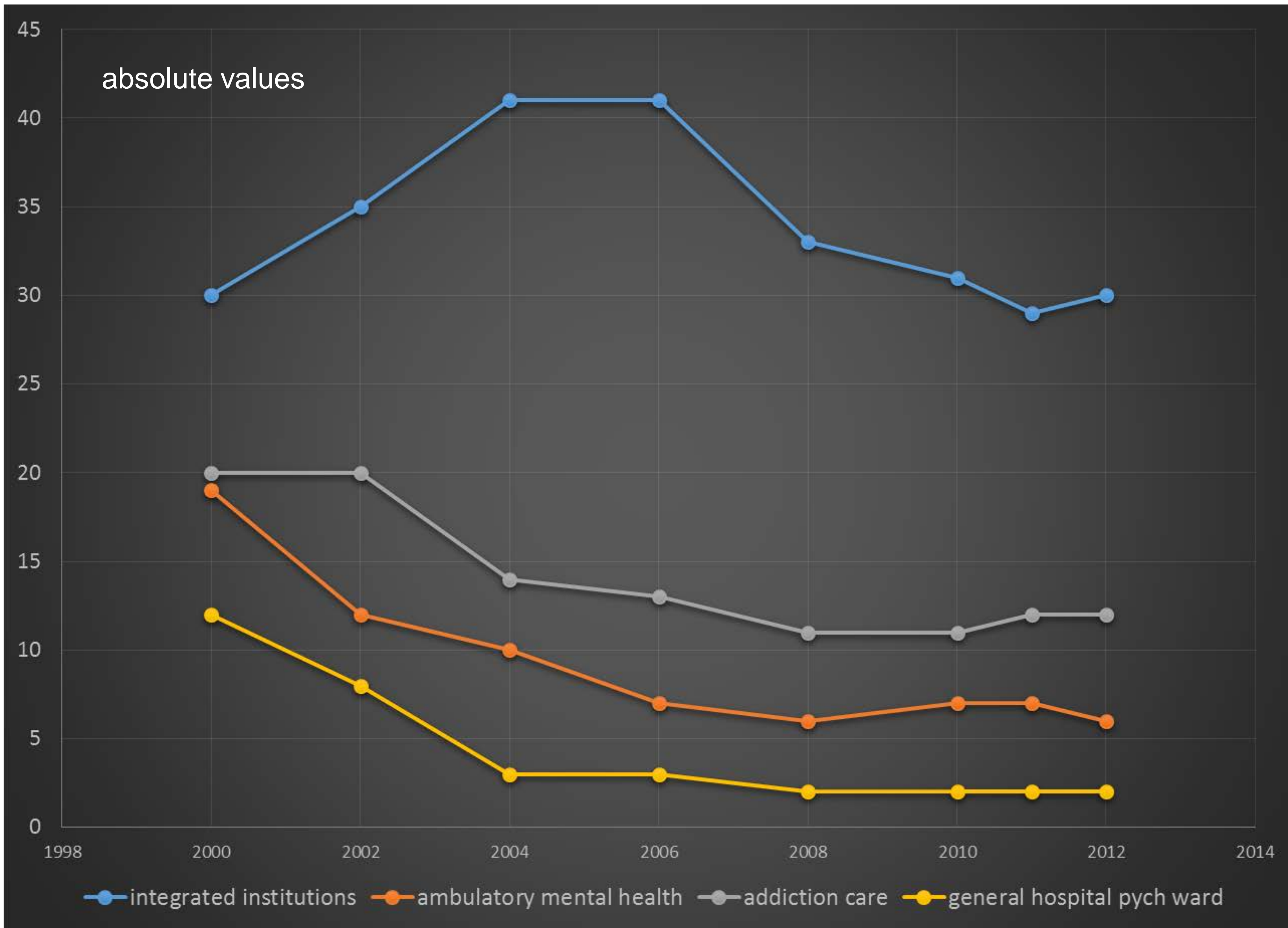
- Developments relevant for integrated treatment:

Scaling up

Drug policy

Scaling up

- Broad, integrated psychiatric institutions
- Offering:
  - Ambulatory (outpatient) help
  - Clinical facilities
  - Residential facilities (sheltering living)
  - Vocational and daytime activity services
  - Prevention and general services



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Our image abroad…

Key notions in Dutch drug policy

- Realism: drugs / drug use endemic phenomenon
- Pragmatic rather than principle-based: do what works best
- Personal freedom: reluctance to infringe on individuals' rights
- Health protection and harm reduction: don’t make problems bigger than they already are
- Separate markets for hard and soft drugs: coffeeshops

Dutch (mental) healthcare

- Developments relevant for integrated treatment:
  - Scaling up: addiction care and menthal health within one organisation, integration easier?
  - Drug policy: acceptance of druguse, acceptance of patients who are willing to change their behaviour (yet).

Dual disorders

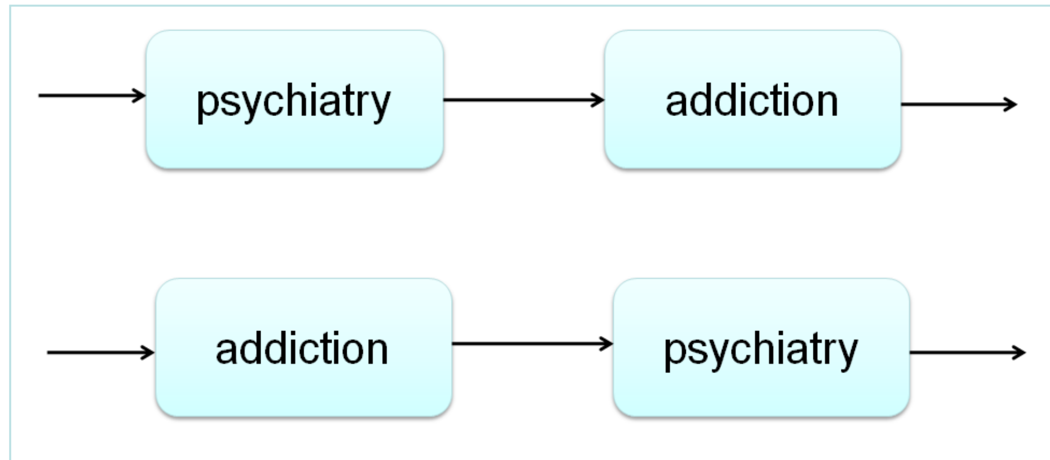
FreeDigitalPhotos.net

Estimates Dual Disorders

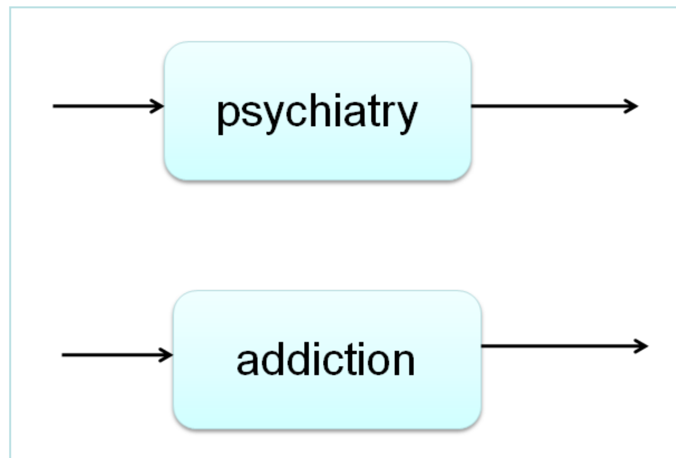
- Mental health care clients : 20% to 50% has (at least one) co-occuring SUD
- Addiction care clients : 60% to 80% of clients has (at least one) co-occuring mental health problem

Treatment models

- Sequential

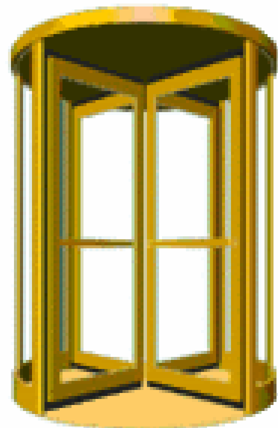


- Parallel



Consequences

- One disorder remains untreated
- Were to begin and when to stop?
- Limited or no communication
- Separate treatments, different views
- Client responsible for integration
- Differences in approach and vision
- Result:



Philosophy on dual disorders

- Comorbidity is the expectation, not the exception.
- Both disorders are chronic and biopsychosocial in nature.
- Both disorders are primary.

(Minkoff, 2001)

Principles Integrated Treatment

one multi-disciplinary team of dually trained professionals	based and working from one location	integrated treatment of both disorders	treatment matches motivational stage of change of client

Benefits integrated treatment

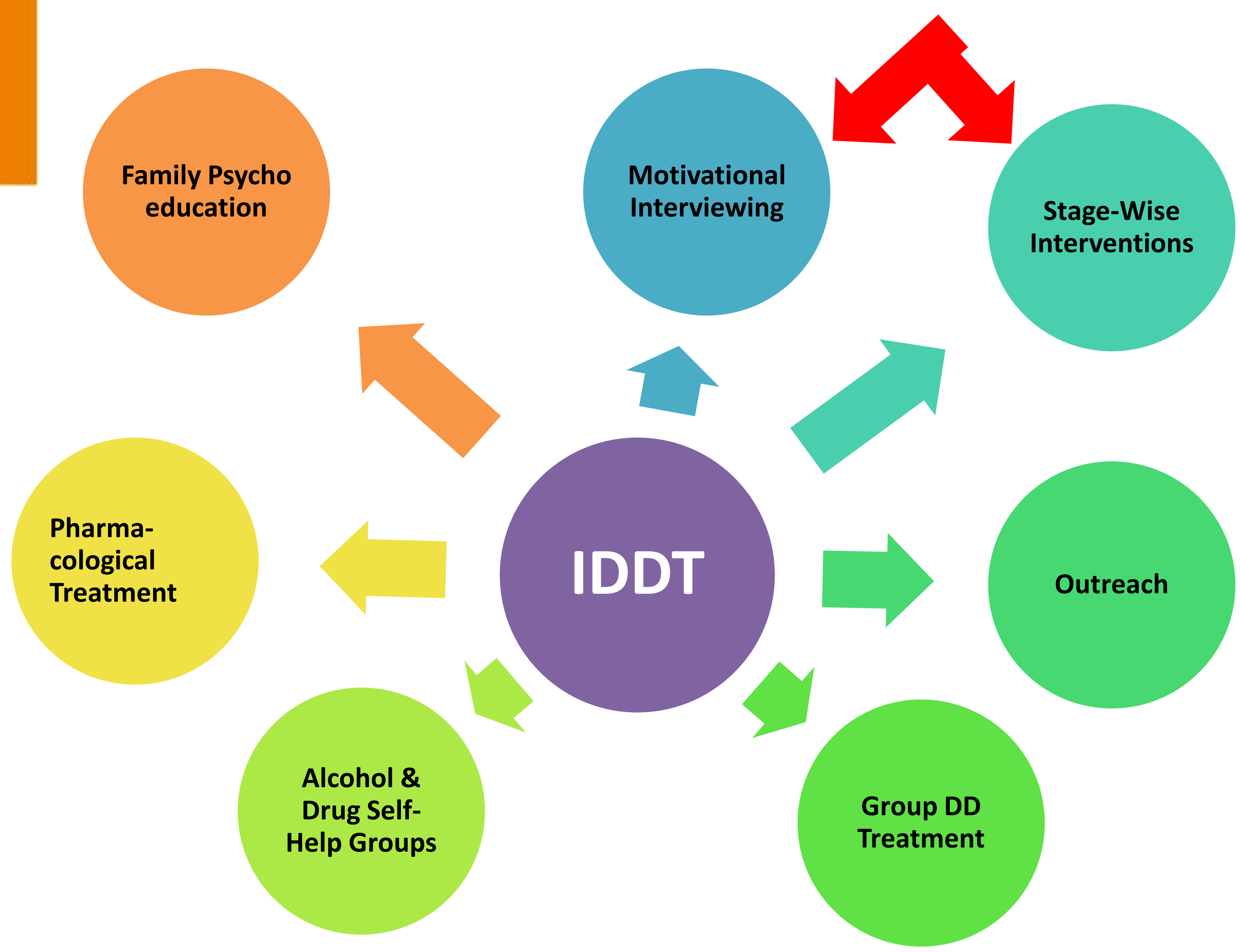
Reduction in

- Relapse of substance abuse and mental illness
- Hospitalization
- Arrest
- Incarceration
- Duplication of services
- Service costs
- Utilization of high-cost services

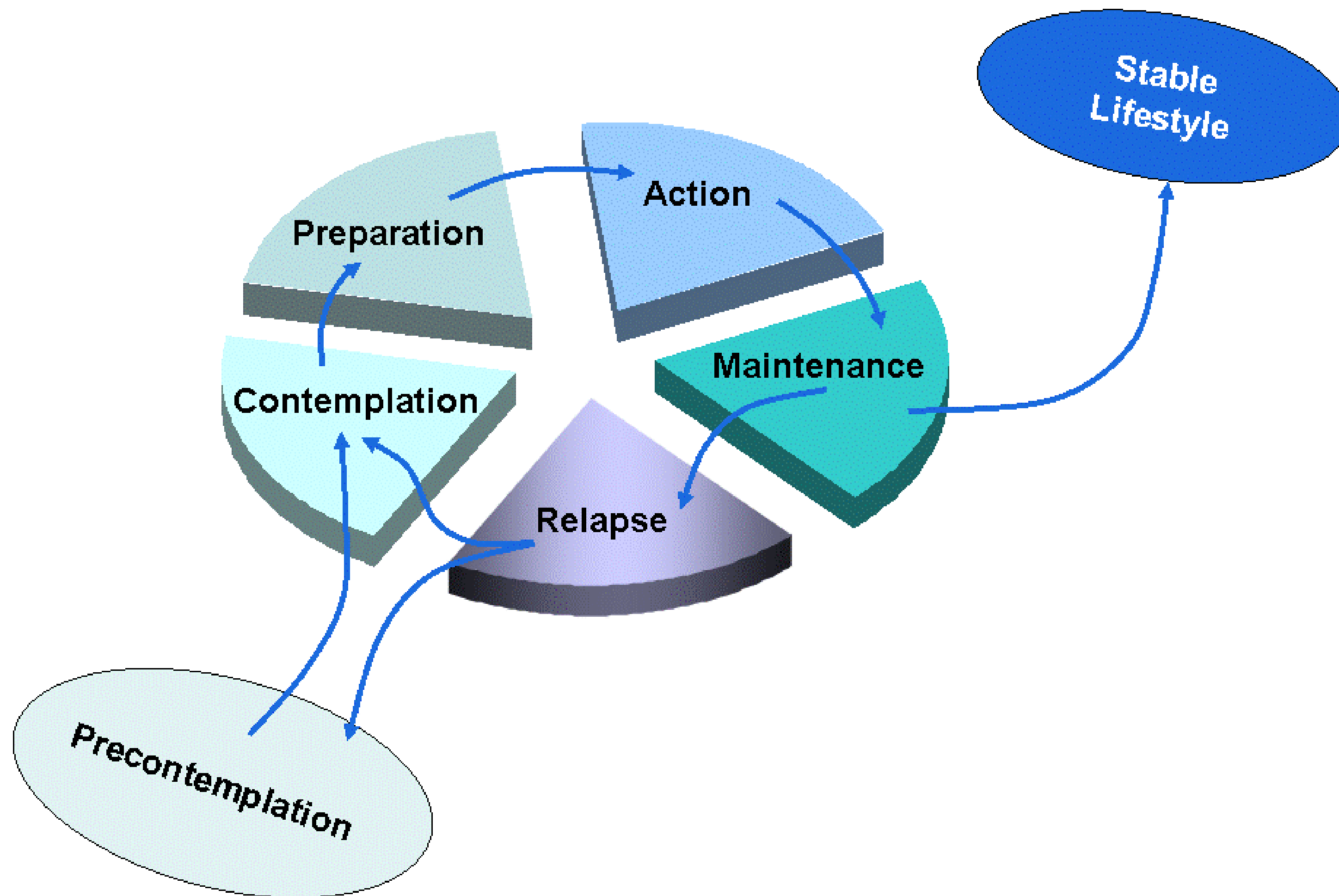
Increase in

- Continuity of care
- Consumer quality-of-life outcomes
- Stable housing
- Independent living

treatment -13



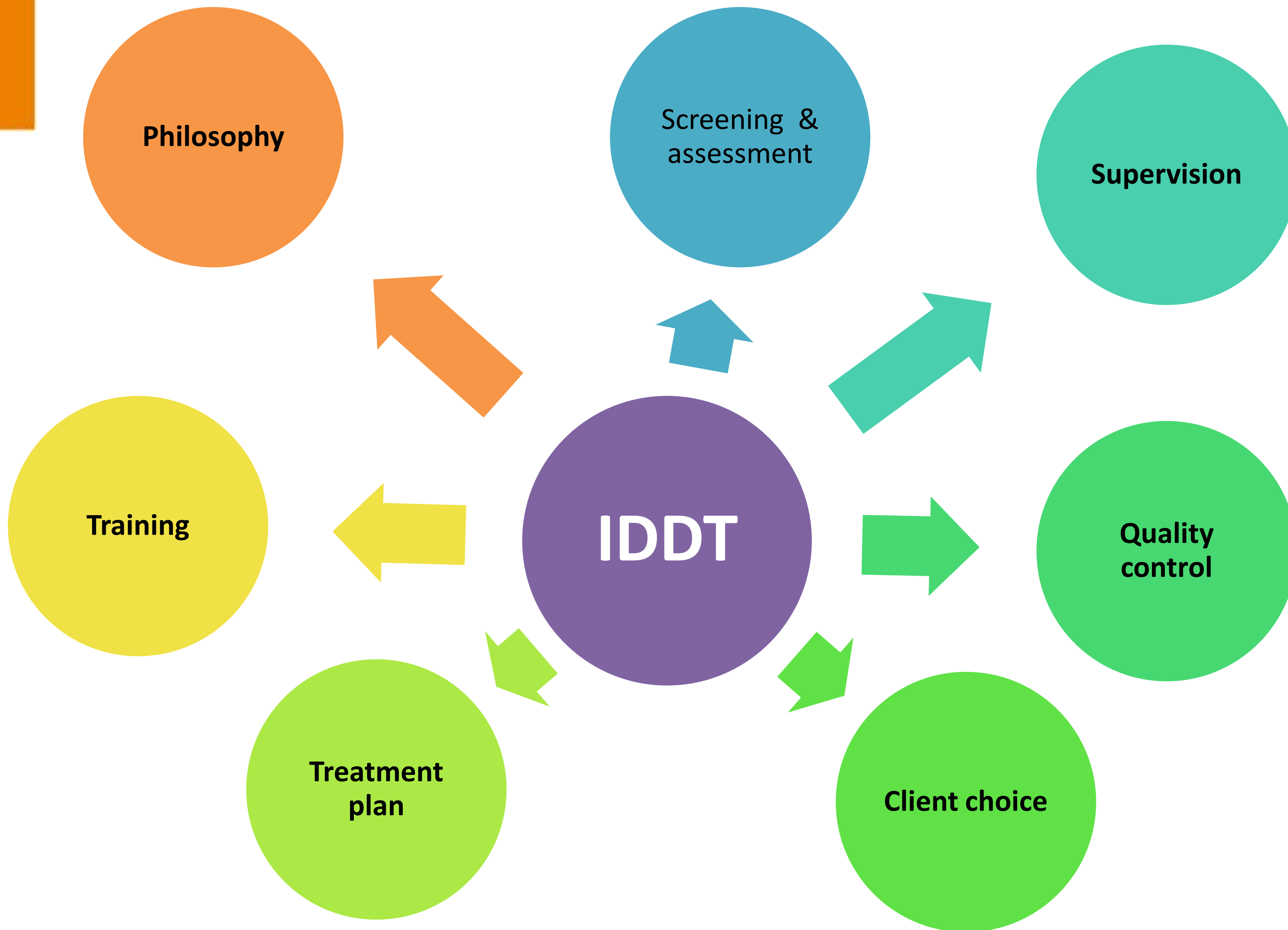
Stages of change model



A means to an end

Stage of change	Stage of treatment
• Precontemplation	• Engagement
• Contemplation	• Pursuasion/motivating
• Preparation	• Pursuasion/motivating
• Action	• Active treatment
• Consolidation	• Relapse prevention

organisation-12



Implementing integrated treatment

First Wave Implementing IDDT

2004-2006 pilot study

High fidelity implementation of IDDT in 5 outpatient mental health teams

Deciding whether integrated treatment can be implemented in the Netherlands

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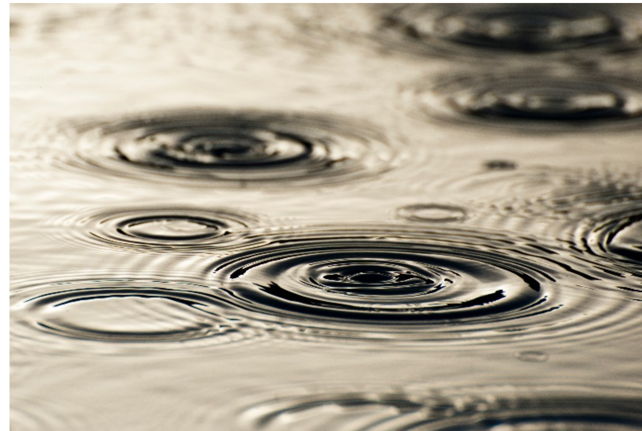
Second wave: 'breakthrough'

- **Implementing IDDT**

- 2007-2008 Breakthrough project Dual disorders
- Since then:



What changed?

- Attitude
- Sense of urgency
- Working with stages of change model
- Start with motivational interviewing
- Level of expertise on drugs and addiction
- Contemplation groups

What remains difficult?

- Comprehensive treatment (both disorders in all stages)
- Group treatment
- Selfhelp
- Family participation
- Screening, assessment and monitoring
- Safety, rules and vision
- Integrated treatment plans

Recommendations

- **Ask the right questions!**

- Why do we want this?
- Who will benefit?
- Is this the right time?
- Can we do this?
- Who can help us?

Final recommendations

- No shortcuts: complex implementation proces
- Internal motivation of teams
- Top down and bottom up
- Make adjustments to match teams specific characteristics

Current situation

- Growth in integrated clinical and outpatient services
- Integrated care for youth and adolescents
- Triple disorder: including (mild) intellectual disability
- Integrated forensic care

- But: still not high on the national agenda…

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Discussion

- The national drug policy has a great influence on the way integraded DD treatment is implemented.
- Specialised DD facilities are an organisational weakness: care for DD clients should be integrated in regular mental health & addiction care
- Integrated care is not always the ideal, under certain circumstances sequential treatment is preferable.
- The benefits of a thorough assessment is outweighed by the time it takes.